the psychiatric Bulletin

FOR THE PHYSICIAN IN GENERAL PRACTICE

WINTER, 1959-1960

RETRIBUTION AND NEUROSIS - PAGE 16

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for the physician in general practice

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The Cover

● The name of *Nemesis* derives from a word that meant to deal out, impute, or distribute. Nemesis was the Greek goddess of retribution, the one who meted out just punishment. With human guilt there is often expectancy of a penalty in some way equivalent to the wrong committed. An article about this concept begins on page 16.

● The cover drawing is by Joseph F. Schwarting.

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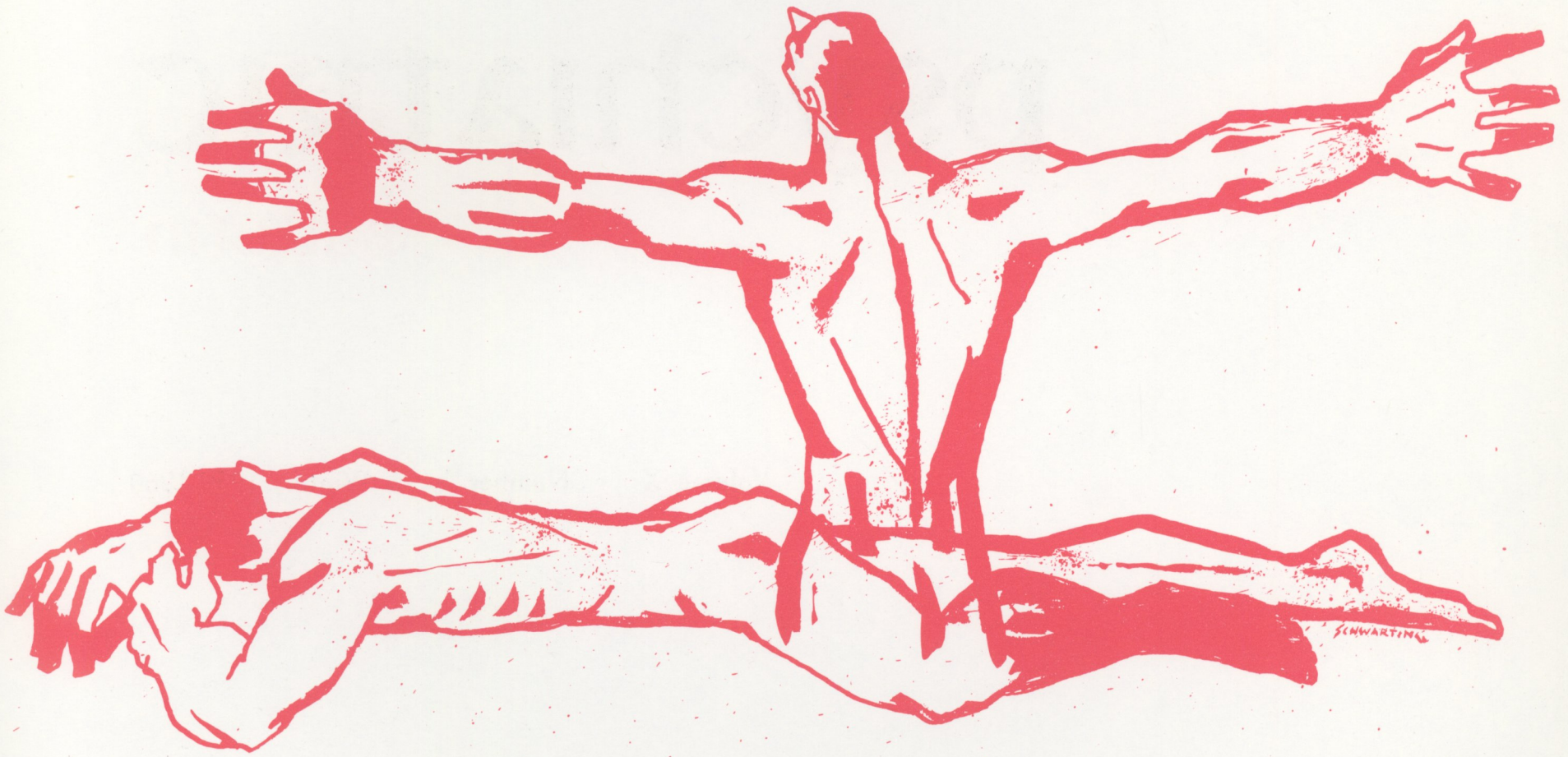
Emotional Aspects of



THE EMOTIONAL ASPECTS of multiple sclerosis have been extensively investigated. Although the subject is still disputed, there is little doubt that the syndrome provides an excellent example of an illness with psychogenic as well as organic elements. The family physician will wish to consider the common emotional traits among patients, the emotional reactions, and the value of psychotherapy in the alleviation of their particular emotional problems.

Harrower, in 1950, reported studies of psychological testing among 61 patients with multiple sclerosis. Control groups included patients with equal physical handicaps from tabes dorsalis, poliomyelitis, or Parkinsonism; patients with neurotic and psychosomatic difficulties; and persons asymptomatic at time of testing. The incidence of certain traits was significantly greater among multiple sclerosis patients. These included passive dependency, less conscious or unexpressed concern with bodily symptoms, minimal inner conflict or resigned attitude, and a tendency to view the world and fellowmen in an unrealistically optimistic fashion. This combination of traits was at first considered characteristic of the "premorbid personality." Nevertheless, since individual patients deviated widely from this pattern, Harrower and Kraus studied 140 subjects in varying stages of the disease. A large percentage of those with remissions showed greater awareness and more capacity for psychological experience. These patients could allow the anxiety secondary to physical symptoms to become conscious. In contrast, patients with advanced disease, as a group, displayed less intellectual awareness, greater personality constriction, and greater disregard of bodily symptoms. Thus, observed changes within the groups of patients made it appear unlikely that psychologic factors predispose to disease. The authors believe, instead, that multiple sclerosis imposes certain standard conditions on the individual patient but that the impact of disease varies in degree and that this is determined by the patient's basic personality structure.

In the latter part of the nineteenth century, Charcot emphasized the importance of the diagnostic triad of nystagmus, dysarthric speech, and intention tremor. He was aware that intellectual and emotional changes were common among patients with multiple sclerosis, and recognized undue cheerfulness and a tendency to involuntary laughter as features of the disease, as well as an increase in lability of affect. "It is not rare," he wrote, "to see these give way to foolish laughter for no cause, and sometimes, on the contrary, melt into tears without reason."

Wilson and Bruce believed the triad of euphoria, eutonia, and increased emotional display to be even

MULTIPLE SCLEROSIS

more characteristic than Charcot's triad. Other writers, including McAlpine and co-workers, have disagreed, or have maintained, at least, that such changes in affect are unusual at outset of illness unless there is widespread involvement of the brain stem. Likewise, early signs of intellectual deterioration are uncommon and occur only when the patient has extensive cerebral disease.

Some authorities are of the opinion that anxiety, depression, and pessimism are characteristic reactions in multiple sclerosis, and that these reactions are extreme in some cases. Gallineck and Kalinowsky state that psychological impact of knowledge of diagnosis is often disproportionately severe in relation to degree of physical incapacitation. One of their patients, they discovered, had made a suicide pact with her husband after concluding from medical textbook descriptions that she had multiple sclerosis. Actually, at neurologic examination for final confirmation of diagnosis, she was found to be in a state of complete remission.

Corroborative evidence of passive-dependency and basic insecurity has been described by Shontz, who stated that groups of patients in his institution were unable to act with unity because there were no leaders among them. Each patient was as uncertain and as troubled as the next. Nevertheless, the patients were united, in the sense that they considered themselves the "least liked," "most neglected," and "most hopeless" group in the world. In group sessions, they became hostile toward the hospital, themselves, society, and each other. With continued association, they finally came to think and speak only of their misfortunes. Patients who adapted best to their limitations, Shontz observed, were the ones who could resist the pressure of patients who were less well-adjusted.

Value of psychotherapy

Psychotherapy offers as hopeful an approach to treatment as any other method at present, according to Langworthy. Patients usually evidence a need for a physician to become interested in them and to offer support and encouragement. According to Shontz, a person with severe multiple sclerosis is often extremely sensitive to any suggestion that he is being abandoned, rejected, or granted fewer opportunities than others. This investigator advises that such patients continue to participate in individualized programs of physical and occupational therapy, even though physical progress is not apparent. Institutionalized patients should not be housed or grouped with other multiple sclerosis patients, but instead with those whose physical conditions are basically stable, as, for example, amputees, paraplegics, or patients with controlled diabetes. Their lives should be given as much structure and certainty as possible through use of regular, unchanging schedules and the establishment of secure routines.

Although supportive psychotherapy is usually all that is required, deeper analysis of neurotic attitudes is necessary in some cases. Gallineck and Kalinowsky have employed this type of treatment, and also phenothiazine derivatives and electroconvulsive therapy for patients with severe depressive reactions. Schumacher cites Langworthy's opinion that corrective psychotherapy for multiple sclerosis patients is an empirical experiment which has given only inconclusive results. Other investigators have obtained good results with psychotherapy in small numbers of severely disturbed patients, even though the relationship of psychotic reactions to multiple sclerosis is not clear. Alexander has employed hypnotic and waking suggestion, as well as supportive, exploratory, interpretive, and abreactive techniques. He believed that, in his patients, there were hysteric, depressive, or anxious "overlays." Geocaris questioned whether there might not be merely a coincidence of two unrelated conditions in multiple sclerosis patients with psychotic episodes. Whatever the relationship, prompt, psychiatric treatment is advisable in such cases, as emotional stress may cause exacerbation of symptoms unless it is alleviated or removed.

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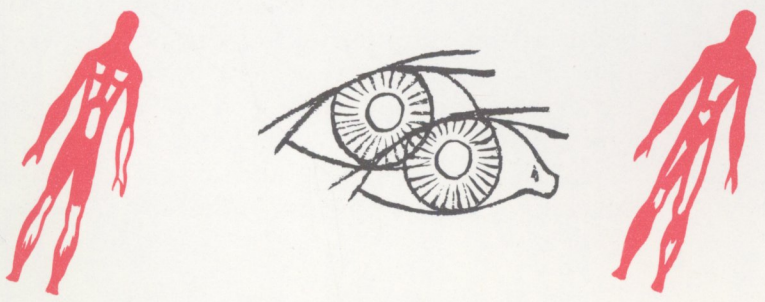

Day Hospitals

The day hospital for psychiatric care is a recent and important development. As it is defined by Craft, the day hospital is "one where full hospital treatment is given under medical supervision to patients who return to their homes each night."

The concept of hospital care has been a variable one. Lately, the purpose, methods, and suitability of such public services have been reexamined, with an expansion of the concept, particularly in reference to the care of the mentally disordered patient. The multiple manifestations and stages of psychiatric diseases and the recently recognized vagaries of emotional effects in other organic diseases have been brought to scientific attention, along with the differing needs of the patients. Inadequate facilities for psychiatric care are well known. Modern medicine has come a long way from the "torture chamber" or "total neglect" types of custody. There is yet much to be accomplished, if patient care is to be more than mere confinement for many patients whose particular requirements are insufficiently met in current practice. Thus, there are constantly under trial new methods of housing as well as of treating the patients. Among such worthwhile efforts at innovation are the neuropsychiatric unit in the general hospital, the halfway house, and, more recently, the day hospital.

Day hospitals have been in operation in this country for only a little more than ten years. Like the other two facilities, such institutions have the important advantage of being disassociated with the unfortunate and unfair popular opinion of the state mental institution. As Goshen words it, there is "a certain, undesirable reputation in the mind of the public which sees the state hospital as a place reserved for patients who have reached the ends of their ropes, psychiatrically, and therefore filled with chronic, deteriorated psychotics."

Most of the few existing day hospitals were started because of local lack of available facilities. They were not planned, as such, for a variation in conventional institutional care, although they have come to serve just exactly that important function. They are not alike as to equipment, scope, or age and stage of patients admitted. They are not united by being the locus for one particular form of therapy. They have in common the features of supervised programs of patient activity, that is, planned work, play, and directed efforts at social adaptation.

Specialized services of vital importance can be illustrated by some of the day hospitals that have been in operation. The first of any kind opened in Montreal, under the supervision of Ewen Cameron, at the Allen

Memorial Institute of Psychiatry. The Montreal General Hospital reported such a service in 1952 at their Day Centre. This program was planned primarily for patients in early stages of illness who could still meet part of their social and familial obligations. These would include, according to Moll, those "for whom it is not desirable that they should withdraw completely from the world into a 24-hour-a-day hospital." The group approach to treatment is the order in this hospital, to aid the patient by gradual improvement of interpersonal relationships. He is brought into group situations and induced to share problems and experiences. Formal group psychotherapy is part of the program, as well as occupational therapy, education sessions, and social diversions. Detachment from home situation is discouraged, as is dependency upon the Day Centre. Outside involvements and interests are encouraged.

Entirely different—at another extreme—are the patients in the League School in Brooklyn. Children between three and 13 years of age who have had a diagnosis of schizophrenia are admitted. This hospital is certainly a "bridge" facility but in another sense. Freedman points out that the unreal environment of the institution is not wholly desirable for the schizophrenic child who is, already, unrelated to his community, in a sense, and who greatly needs assistance in environmental adjustment. Obviously no hospital could answer all requirements because of the varied manifestations of the disorder in childhood; however, applicants are screened for this school and care taken that it be the proper environment for such patients. Schizophrenic children are ill-suited for residential or hospital care and are unacceptable in most schools. Thus, educational assistance and relationships with other children are forbidden to these patients. On outpatient status the child sees his physician too little for effect upon his way of life or even to reduce his anxiety. When schizophrenic patients spend their whole childhood at home, without the influence of their peers or of school, they become more than ever dependent and less able to adjust in any fashion. If the presence of the child in the home brings about a serious hardship, as in affecting the maturation of healthier siblings, the result is often unfavorable, and the parents are seriously affected in their relationship to the sick child. For these, among other reasons, the day hospital is a desirable solution. The child's contact with home and family is maintained; his academic life may

possibly be continued; and he is housed in a form of group living that can be health-giving.

In this particular center there are no more than three children under the care of any one teacher. The staff includes 14 teachers for 38 children with, in addition, a director and a psychiatric director, a psychiatric social worker, both dance and music therapists, two psychologists, and administrative and housing personnel. Play is used to "reach" the child, but he is taught lessons, according to his ability, encouraged to participate in group activity, given psychotherapy, and his parents are afforded counselling services. Freedman says, "The teacher operates on many levels to suit the needs of the particular child. This may range from merely holding the child on his lap. . . ."

A final illustration is afforded by a third type of service, reported by Kris. In this day hospital patients who had been discharged from mental institutions received treatment after relapses to forestall further hospitalization. At this day hospital the individuals were given phrenotropic drugs and were supervised by a psychiatrist and a nurse.

An occupational therapist saw that their time was filled and a social worker gave help on their family problems. This temporary place of temporary help seemed to serve a valuable purpose. In 26 patients results were favorable, and all of these had relapsed after a seemingly fortunate adjustment to community living.

Advantages

The advantages of the day hospital are numerous and are seriously to be considered in the current shortage of accommodations for the emotionally ill. From the day hospital there is no need for a "bridge" such as the halfway house — between hospital and home. Some day hospitals serve that purpose, at present.

Individualized care and attention are possible in this kind of situation to an extent that cannot be realized in the usual large mental hospital. The factor of numbers—of patients and of personnel—is not the only reason for this difference. The hours and circumstances are such that this advantage accrues naturally.

The third advantage can be better realized by examination of records of individual day hospitals. It amounts to the handling of special problems, such as, for example, that of the school age child with a psychiatric handicap. In the troubles of certain ages or types of patients day hospitals have a definite value. Some of them are literally directed to solution of a particular problematic situation.

Perhaps the chief advantage—as well as disadvantage—of the day hospital is implicit in the name. The care is not total; hospitalization is not entire; the connection with home and society is not severed. Patients maintain their family status, so to speak, their connection with events in the community, and their family unity or lack of it. The patient who is mentally sick is, by this means, still not isolated from the family members or from friends who are well. Socialization, if it is ever to be attainable for the patient, is more likely if all ties have not been cut.

Disadvantages

Hospitals of this sort have disadvantages, of course. They are slightly more expensive than many public institutions, while still excluding around-the-clock care. In terms of

duration of hospitalization this difference could, perhaps, be resolved.

For obvious reasons, day hospitals cannot include all age groups or all types of mental disorder. Indeed, by so doing, some of their effectiveness would be lost; nevertheless, in particular communities this amounts to a disadvantage. Actually, many varying needs are met by day hospitals.

Potentially some risk is incurred. This is not in reference to a patient who is endangered or incapacitated by neglect. Instead, there is the possible public hazard of deranged persons who are not confined. Legal responsibility is a factor, and both patient and public are theoretically threatened. So far there have been no serious involvements of this sort.

The patient in a day hospital is not wholly removed from the environment that may have contributed to or exacerbated his distress, an argument that is certainly valid in many instances. The intent of treatment is, however, individual restoration to the maximum degree that is possible, and, for such restoration, for any kind of rehabilitation, social adaptation is a major objective. The patient's contact with reality and his assumption of the duties and burdens of society are significant parts of the curative process. To be "in touch" can be used literally of the psychiatric patient's rehabilitation.

Conclusion

Standardization of institutional facilities and care is no answer to the question of how best to help the patient. Forms of therapy vary from organic procedures to psychotherapeutic means. Patients' requirements and situations vary still more. Adaptable methods are greatly needed to help the increasing psychiatric population. Day hospitals were originally developed from exigency, because of the absence of appropriate institutions of a more conventional order. In ten years they have proved useful and, as a means of care, have been found adaptable to a variety of requirements. Although more expensive than state asylums when considered on a daily basis, they are comparable in cost to the neuropsychiatric units in general hospitals. The average duration of patient stay is less, however, and many items of equipment—such as accommodations for sleeping—are unnecessary in the day hospital. The idea is a worthwhile one, and should seriously be considered in communities with inadequate facilities for mental patients.

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Hypochondriasis

An interview with C. Knight Aldrich, M.D., Professor and Chairman, Department of Psychiatry, The University of Chicago, Chicago, Illinois

In your opinion are many presenting complaints of patients seen in general practice of a hypochondriacal nature?

Since I am not a general practitioner, I can only answer from hearsay evidence. From reports I have read, however, and from the interest in emotional problems currently expressed by general practitioners, I believe that a high proportion of their patients suffer from hypochondriacal complaints and from psychophysiological reactions also.

What is the difference between hypochondriacal complaints and psychophysiological reactions?

Any type of fear—and anxiety is fundamentally a fear of an unrecognized, internal, psychological danger—is accompanied by physiological changes. These changes, as Cannon stated, usually have the function of preparing the individual for fight or for flight, the primitive physical response to fear. Since a man suffering from anxiety cannot fight or flee from a danger he cannot identify, he remains in a chronic state of physiological preparedness, evidenced by autonomic disturbances in one or more organ systems, or *psychophysiological reactions*. Examples that could be cited are diarrhea, dyspepsia, and palpitations which are primarily emotional in origin.

Since man usually is less uncomfortable worrying about something tangible than something unknown, he tends to attach or to "bind" his anxiety to definitive objects, situations, or body areas. The resultant *phobias* (fear of objects such as knives, or fears of situations such as closed areas) or *hypochondriacal concerns* (fears of illness) are unconsciously and not deliberately selected, and they are thus beyond the patient's ability to control.

Psychophysiological reactions, therefore, are bodily *signs* of emotional tension, while hypochondriacal concerns are bodily *symptoms*, secondary to, or displaced from psychological causes of tension. The same patient often demonstrates both signs and symptoms, and the diagnosis is determined by the relative preponderance of one or the other.

Where do the manifestations of conversion hysteria fit into this?

In conversion hysteria, or conversion reactions, as they are now called, there are physical disturbances—usually paralyses, anesthetic areas, or defects in special senses—which relieve unconscious emotional conflicts. For example, a paralyzed right arm relieves a hidden conflict about striking someone, because the patient is rendered unable to strike. Conversion symptoms are also frequently seen in combination with psychophysiological signs and with hypochondriacal symptoms as well.

Do you consider malingering to be a conversion reaction?

Not exactly. The first three are all developed below the level of the patient's consciousness, so that he does not know their cause and usually is not aware that they have anything to do with emotions. Conversely, the malingerer is aware both of the cause and the nature of the symptoms, and malingered symptoms are seldom seen in combination with the other three types. The malingerer ordinarily avoids medical workups lest he betray himself, while the others welcome medical evaluation.

Actually, malingering is rather uncommon, and the physician is well advised to assume that symptoms of emotional origin are unconsciously produced until proved otherwise. I suspect that the physician sees, or should see earlier, many more patients who feign health than he does patients who feign illness.

Do you consider chronic physical complaint as a result of emotional disorder to be an indication for referral of the patient to a psychiatrist?

I think the question of referral depends: (1) on the individual patient (how clear is his diagnostic picture;

how incapacitated is he; and is there a definite suicidal risk?); (2) on the physician (how much interest, understanding, and experience does he have with such patients?); and (3) on the locality (in areas where psychiatrists are in short supply, consultation may be difficult to arrange). In general, I believe that the family physician should be able to manage, perhaps with occasional consultation, the majority of patients of this type.

In instances of persistent disorder for which no organic reason can be ascertained do you think that the use of placebo is justified?

I am not enthusiastic about placebos. It seems to me that they put the physician in a complicated bind. He either has to go on giving the placebo indefinitely, which convinces the patient his illness is organic and prevents getting at the real cause, or, at some time, he must acknowledge that he has deceived his patient. Even when deceit is carried out for one's own good, it does not inspire confidence. If I could be sure in any case that the tension would be of short duration, I might object less to placebo treatment. Unfortunately, most emotional problems are chronic.

It has been said, often, that nothing curative can be done for the true hypochondriac. Do you agree?

No, I am not that pessimistic, although when hypochondriacal complaints have been presented for twenty years or so and are thoroughly supported by the patient's family environment, I think the chances of anything "curative" are remote.

Could you suggest any psychotherapeutic procedures for the family physician that might be helpful in the management of such patients?

I can only briefly summarize by saying that environmental modification and medication are often used too freely by the family physician, that insight psychotherapy requires special training, and that psychological support, through understanding, can be extremely helpful. Such support includes listening, appropriate reassurance, and cautious clarification of alternatives, attitudes, and any areas of confusion.

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Psychiatry and William Harvey

In the seventeenth century, as in the present one, the percipient physician recognized the retroaction between emotional problems and physical health. This passage would now be classified as relevant to psychosomatic medicine: ". . . every passion of the mind which troubles men's spirits, either with grief, joy, hope, or anxiety, and gets access to the heart, there makes it to change from its natural constitution, by distemperature, pulsation, and the rest, that infecting all the nourishment and weakening the strength, it ought not at all to seem wonderful if it afterwards beget divers sorts of incurable diseases in the members and in the body. . . ." The lines are from a volume much better known for another subject—*De Motu Cordis*.

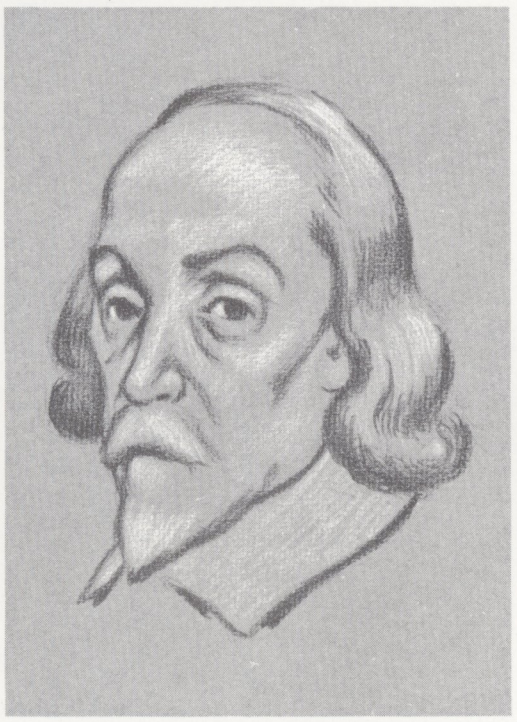
The multiplicity of William Harvey's interests and the brilliance of his career are rewarding to review. Because he is chiefly associated with studies of the cardiovascular system and of embryology it is easy to forget some of the other types of research he undertook, actually to forget his clinical practice entirely. Indeed, some students have suggested that Harvey himself separated those disciplines and had little thought of applying his findings to the patients at St. Bartholomew's or elsewhere.

Harvey came to St. Bartholomew's

after an outstanding academic career. He was born in Folkestone in April of 1578 and had gone to the oldest school in the country, Canterbury, for his preparatory training. At Gonville and Caius College, Cambridge, he had the unusual Parker scholarship for medical training, and he took his Bachelor's degree in 1597. He became Doctor of Physic at Padua in April of 1602 after an extraordinary record of achievement, popularity, and distinction. In 1607 he became a Fellow of the College of Physicians, in 1613 the College's Censor, and in 1615 the Lumleian Lecturer in Surgery, in which appointment he remained until 1656. His famous announcement in the first Lumleian lecture, and, 12 years later, its publication are too well-known to require discussion. Harvey's views on mental and emotional disorders are of interest, however, and despite the serious handicaps of the era in which he lived his contributions are not unimportant to the development of psychiatry.

The interrelation of mind and body is suggested and discussed in more than one of Harvey's writings and not only in reference to cardiovascular disorder. He is said to have told Bishop Hacket, a patient of his, that more people, in his observation, died "of grief of mind than of any other disease." According to Hunter and Macalpine he referred to the number of disorders "generated from the mind" during the period of the rebellion, also in conversation with the Bishop. In *De Circulatione Sanguinis* he cited the history of a patient personally known to him "who, for anger and displeasure over a wrong done by someone stronger than himself and over an affront inflicted, became very inflamed and excited. With his ill will and hatred mounting daily because revenge was forbidden, and disclosing to no one the severe mental suffering which so very greatly exasperated him, he at last fell upon a strange kind of disease, and was miserably tormented with very great oppression and with pain in the heart and chest." Harvey then described the downward clinical course of this "prudent man" and the futility of treatment. At last he died of "a scorbutic cachexia." At necropsy the heart and aorta were found to be distended and engorged.

Harvey wrote of the effect of the passions upon the countenance and the physical changes produced by anger or lust. In his lectures and writings, Hunter and Macalpine say that he also referred to mania, alcoholism, insanity, hypochondria, hallucinations, melancholy, imbecility, and somnambulism. Harvey described pseudocyesis, a number of hysterical manifestations, and *folie a deux*. In his accounts, the terms "prolapsus uteri" and "furor uterinus" are employed, along with some commonsense observations upon hysteria. Although most of the described conditions were known to medicine at the time, he did write with insight on these subjects, and his instance of *folie a deux* is said to be one of the first such descriptions.



In Aubrey's opinion Harvey was little liked as physician although respected as anatomist. Other contemporary evidence does not corroborate that idea, though. Harvey referred in his writings to friendships with various physicians—Argent, Ent, and Selden, among others. Selden is said to have referred a mentally ill patient to Harvey. Hollier, a surgeon at St. Thomas's Hospital, had a patient with hysterical anesthesia, apparently, of whom one account reads: "That this Maid having remained a great while in the Hospital without being cured, Dr. *Harvey*, out of Curiosity, visited her sometimes; and suspecting her strange Distemper to be chiefly Uterine . . . he advised her Parents . . . to take her home, and provide a Husband, by whom, in effect, she was according to his Prognostick, and to many Mens wonder, cur'd of that strange Disease."

According to many medical historians modern medicine began with Harvey. Truly before his historic findings much of the natural development and maturation of research was all but impossible. Besides his careful studies in his best known subjects he also afforded yet another example of the true scientist both in his refusal totally to reject the old and in his unwillingness to accept any precepts unquestioned. In the words of Lain Entralgo, "Seen from within, the scientific contribution of Harvey reveals to us the Janus-like condition of its author. One of his faces is ancient, the other modern."

Harvey's life was a full one and a rewarding one. He lived to be almost eighty; he was well, except for gout, most of the time; and he had situations of honor and importance always, including royal positions with both James I and Charles I. He married the daughter of Sir Lancelot Browne who was, according to Wright, the most successful physician of the day. Although his theories of the circulation were subjects of dispute and ridicule they were not neglected. Some of the outstanding nonmedical individuals of the era supported his theories. By temperament Harvey was not one to suffer by his colleagues' partial failure in understanding, and he continued in a busy and successful fashion to the last of his days. He died in 1657. Aubrey says, ". . . Palsey (of the tongue) did give him an easy Passe-port."

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Facial Tics

"It has been said that the frequency of tic is in direct proportion to the civilization of a people. If this be true we must be highly civilized." Thus spoke Charles Herrman in a paper read before the Society of Medical Inspectors of the City of New York, on May 1, 1906. At that time, Herrman listed two important etiological factors as, first, the inherited predisposition or the favorable soil, and second, the environment, including the method of training.

Herrman, at the turn of the century, expressed the theories of his time. The ensuing 50 years have brought further understanding.

Tic is explained as "a coordinated purposive act, provoked in the first instance by some external cause or by an idea; repetition leads to its becoming habitual, and finally to its involuntary reproduction without cause and for no purpose." Tic consists of sudden, abrupt, rapid, involuntary contractions of a muscle or group of muscles. It generally is clonic, but if the movements follow in rapid succession may become tonic. The clonic muscular twitching may be limited to the eyelids alone, the lips, the upper part, or the whole side of the face. Generally all the muscles of the face that are innervated by the seventh nerve are involved. Sometimes the platysma and even the ear muscles are included. The orbicularis palpebrarum is a common site of tic. When the whole face is involved, the eyelids are closed, the face and forehead wrinkled, and the nose is drawn to the affected side. Excitement, emotional strain, chewing, and swallowing increase the intensity. Three characteristic features of tic are: occurrence in functionally related groups of muscles; association with an irresistible tension which is relieved only by performance, and with anguish should the urge to act be denied; and partial control by the will. Classification of tics on a psychological basis presupposes a theory of pathogenesis and a notion of the function that a tic serves. If the tic is regarded as a psychoneurotic motor phenomenon, primary and secondary tics must then be differentiated. Primary tics represent a discharge of aggressive or erotic feelings in an instance of impaired or inadequately developed ego. Such tics are extremely common among young children and are caused by overstimulation or excessive restriction of spontaneous motor activity.

Primary tics are a result of conflict between the child's urges and the requirements of his environment. The movements usually disappear during childhood as the child gains in adaptability and acquires other methods of mastering tension; however, a fixed tic may develop if excessive restriction or overexcitation persists.

Secondary tics are motor phenomena which the ego employs as defensive measures against the feelings which it is impelled to express. This is the type usually seen.

Facial tic is one of the most common conditions of childhood. Blepharospasm, a form of tic, may vary from the occasional eye-blinking of the nervous child to severe and constant spastic closure of the lids. The spasm may be limited to the orbicularis or may extend to the muscles of the face and neck. A patient may attempt to suppress the spasm and develop a defense against it. In doing this, he may unconsciously displace the tic from its original site to another part of the body and another form, such as a compulsive act of the hands. Defense may thus be converted into a secondary tic or "paratic."

It has been suggested that patients with tic are emotionally infantile. Narcissistic impulses normally should decrease as the individual develops emotionally and learns to love objects and people besides himself. Onset of tic in children has been reported after a school fight with a bigger child, after a severe scolding, and after a fright by a dog. Blepharospasm after such traumatic situations may be evidence of a "shrinking from danger." Blinking has also been noticed in children who have had to read before the class, as standing before the class is a threat to self-esteem. Children who have forbidden desires to explore sexual subjects or have observed activities of their parents may react by blinking. Jealousy after the birth of a sibling may cause hostility in an older child, with death wishes for the "intruder." These wishes bring about a feeling of guilt and tic may then develop as self punishment for the repressed feelings.

As the individual matures, defensive measures alter the methods by which instinctual drives are satisfied. Denial by word or act, undoing, or intellectualization contributes to development of the compulsive ritual, which is a series of acts designed to protect from guilt or anxiety of repressed impulse. Both the tic and the compulsive ritual serve as gestures of defense against trauma or conflict. The tic develops in the immature individual before the intellectual ability and the capacity for

mastering anxiety have developed. Some authors believe that the defensive function of tic should be stressed, because it enables repression to be maintained and conflict resolved.

Tics must be differentiated from abnormal muscular movements that occur in neurological diseases. A patient with Huntington's chorea can be distinguished by his almost complete inability to control symptoms, and by lack of anxiety and tension in cases in which some restraint is possible. Sydenham's chorea involves many muscular movements, which seldom are duplicated, a gross exaggeration of all normal gestures, and general disturbance of motility. The twitches of clonic facial spasm may show similarity to tics, but the contractions are fleeting spasms which cannot be reproduced voluntarily.

Treatment

Emotional conflicts are easier to dislodge in children than in adults, and conflict may be relieved by having the patient "talk it out." Such ventilation is a time-consuming process, but often parents can be taught to help the child by listening to him. Children frequently outgrow tics or blepharospasm. They grow emotionally and learn to love others, but predisposed children may need help.

Enforced quiescence of the twitching part is an advantageous method of treatment. Improvement is more marked if the patient controls himself by looking in a mirror. Glasses may prove of some value to certain patients. They may serve as a protection to the child—a barrier against forces in the outside world—but they should not be used as placebo. It is obviously preferable if the problem can be met directly.

Treatment of adults is much more difficult, as the condition has persisted for a longer time and the patients will not outgrow their self-love without help. Most such patients have to be referred to a psychiatrist for intensive therapy.

The intent of treatment should be achievement of understanding and of the patient's interpreting the tic as a defensive act. The chronological relation of the development of the tic to various life situations and emotions should be clarified. Weisman states his procedure in treatment of adults is to discern the symbolic significance of the tic pattern as early as possible and interpret it to the patient. This may facilitate the patient's recognition that apparently meaningless movements are informative to the physician. A real source of information is afforded when the therapist witnesses the occurrence of tic when certain topics are discussed.

One of the important needs of the patient is to feel accepted. The need for ego support is strong, and when the anxiety or depression that develops during treatment becomes evident, it is wise to encourage the patient and to augment his more intellectual defenses. The treatment of adults is predicated on direct interpretation of the function of tic, as a fragmentary reenactment of a conflict situation, that is periodically expressed.

Treatment by Drugs or Surgery

Pipradol (Meratran®) has proved effective in some cases of blepharospasm. This drug is contraindicated in hyperexcitability, anxiety, chorea, or obsessive-compulsive states. Other "last resort" methods which may be considered with or in place of psychotherapy are neurectomy, alcohol injection, and myomectomy. These methods may also be harmful, because when a symptom is removed there is always the danger of personality disintegration. The individual may become psychotic.

Case Histories

A ten-year-old boy was referred for treatment because of poor reading and a nervous tic. Vision was good, but glasses were prescribed because of a slight imbalance of hyperopia. He used his left hand for throwing and cutting, his right for eating and writing. The left eye was strongly dominant. The right eye controlled distant vision, but for reading the left eye was better. Occlusion of the left eye and exclusive use of the right hand were ordered. Cutting and throwing with the right hand were practiced during occlusion. In four months right eye control was established. He lost his nervous tic and gained so much in stability that he moved in the family group "like a different child." His reading became excellent.

The boy had two basic problems, hysterical tic and an emotional confusion from crossed dominance of eye and hand. The training to eliminate the crossed dominance was of sufficient help to the patient that the hysterical tic was no longer needed and was discarded.

A 45-year-old spinster developed hysterical ptosis and blepharospasm after she heard of a series of extramarital affairs by clergymen. She was the daughter of a clergyman who preferred his three sons to his only daughter. She had always competed with boys and been identified with them. Her condition improved temporarily after the obvious interpretation was made that she was shutting her eyes to something. It was only when the whole extent of her repressed sexual life had been brought to consciousness that the blepharospasm and tic disappeared.

Conclusion

A tic is an abrupt, rapid, repetitive movement of functionally related groups of muscles. It is associated with mounting tension unless the urge to perform the movements is obeyed, after which a temporary gratification is experienced. The tic can be controlled voluntarily for varying periods of time, but always with an accumulation of tension.

Tics occur more frequently in children than in adults because of the inadequacy of the maturing ego to cope with excessive stimulation from within or undue restraint from without. Actually the defense mechanisms available to the child are limited.

The adult ego has secondary defense mechanisms, and tic results from preliminary defensive efforts to cope with specific tensions. Only by partial inhibition, restriction, or isolation of the affective content does the ego maintain control. Treatment of adults requires direct interpretation of the function of the tic.

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Exhibitionism

A French physician, Charles Lesegue, first used the term *exhibitionism* in 1877. Although the psychodynamics were subsequently adduced by the psychoanalysts, Lesegue anticipated much later theory in what he called the scientific characteristics of exhibitionism. Lesegue defined the exhibitionist as an individual, "almost always a man," who exposed himself indecently to passers-by. Although the individual at first may have appeared vicious and depraved, investigation commonly showed a good social background and normal physical development. The reason cited for exposure of the genitals before ostensibly unknown persons was that the exposure might be repeated many times before a complaint was made that resulted in arrest of the offender. The exhibitionist made no further attempt at sexual aggression. The act of exposure was usually repeated at the same place and at the same time on every occasion. Lesegue believed that the periodic recurrence and imperative urge to exposure were indications of a pathologic condition. Observations that the subject was ashamed, recognized the absurdity of his behavior, and was indifferent to the consequences were cited also as evidence of disorder.

Dynamics of exhibitionism

According to psychoanalytic theory, during the period of infancy the individual gains gratification of early sexual impulses through the erotogenic zones of the body. The infantile sexual drive consists of several component or partial impulses, one of which Freud classified as exhibitionism. This partial impulse is subject to the same modifications that may occur in the resolution of the other sexual impulses. The exhibitionistic tendency may be displaced, or may be expressed in terms of reaction formation, that is, in aversion to any kind of display. A mild form of exhibitionism may be expressed by work that necessitates display of the body, for example by actors or models. If sublimation, repression, or other defense mechanisms fail, the subject may turn to the most extreme form of exhibitionism.

Freud further postulated a relationship between scoptophilia or the pleasure derived from looking at a sexual object, and exhibitionism. It was Freud's opinion that scoptophilia and exhibitionism are actually active and passive dramatizations of the same basic impulse. He stated that the normal desire to look at a sexual object becomes a perversion only when this interest is limited to the genitalia, when it is associated with ridding the person of shame or loathing, or when it replaces instead of prepares for the normal sexual act. Three stages by which scoptophilia is changed to exhibitionism were described. First, scoptophilia is directed toward an extraneous object. Second, this object is abandoned and the scoptophilic impulse is turned toward the subject's own person. Last is the choice of a new object to whom the subject displays himself in order to be looked *at* instead of looking himself. This last stage represents the transformation to passivity, to being observed rather than observing.

Parental influence

Also inherent in the development of exhibitionism is faulty resolution of the Oedipal situation, according to some investigators. This psychoanalytic etiologic theory, although not universally accepted, is still the most adequate one which has been proposed. Rickles, and, more recently, Ellis and Brancale have found that exhibitionists ordinarily have been emotionally over-protected during childhood and maintain exaggerated relationships of affection with their mothers. In most case histories, the mother is the predominant parental figure, and the usually passive father cannot counteract the excessive and monopolistic effect of maternal influence. Consequently, lack of a strong father figure and concomitant lack of paternal guidance and support cause the child further to increase dependence on the mother. The mother is disdainful toward the father with the result that the boy may feel that he has no competition for the mother's affection, as in the normal Oedipal situation. From this lack of competition, the incestuous drives are fostered, feelings of narcissistic omnipotence are nurtured, and the resultant psychosexual development is arrested at the infantile level of phallic narcissism.

In these subjects, the castration complex also is not based on fear of the superior father-figure, but, instead, on fear of the more powerful mother-figure. The maternal possessiveness is undoubtedly, at least in most cases, an unconscious mechanism, but actually may be the result of the mother's own narcissism, penis envy, and masculine protest. Since such a mother has not been able to accept femininity she compensates by producing a male child who represents the phallus of which she has been deprived. The mother regards

the child as a personal creation. She identifies closely with the son and tries to maintain her domination.

All these factors are considered significant in the development of exhibitionism as a compulsive neurotic outlet. Theoretically, these factors help to explain the exhibitionistic act, in that the son tries unconsciously to become independent of the engulfing mother-figure, and to assert himself as a distinct, masculine individual.

This interpretation of the dynamics of exhibitionism as an attempt to overcome castration fear cannot, obviously, apply to women. Fenichel states that genital exhibitionism does not occur among women but is displaced from the genital region to the entire body. Rickles confirms this opinion that women do not commit the act of genital exposure for the simple reason that "they have nothing to expose." The reason can be explained on the basis of difference between the male and female castration complexes. The female believes that lack of a penis is a narcissitic injury, and displaces the infantile wish to expose the genitalia to a wish to display the whole body *except* the genitals. Examples of female exhibitionism have been cited but usually as part of the symptomatology of other disorders. Guttmann has presented a detailed study of twelve case histories that shows that exhibitionism may occur as a symptom in the most varied mental disorders. For example, exhibitionism occurred as a predominant symptom in psychopathic personalities with and without psychosis, in conversion hysteria, and in cerebral arteriosclerosis. It was a secondary symptom in general paresis, schizophrenia, mental deficiency, senile psychosis, and also in others of the organic psychoses.

An intensive study of the background of exhibitionistic patients shows that there are many patterns of similarity in their family backgrounds and in their features of behavior. In most cases an attitude of extreme modesty is maintained in the home and a strict moral code about sexual subjects is inculcated. The parents seldom give any sex information and usually the subject of sex is not mentioned. The subjects themselves are often described by parents as "ideal" children, and their behavior is characterized as exemplary. As children, the patients were admired and protected so that thereafter they continued to seek safety by trying to remain within the prescribed pleasures of childhood. This safety-seeking explains much about the rigid behavior of the exhibitionist.

In most cases, patients had failed to establish or to maintain normal adult sexual relationships. Although many had been married, only partial sexual adjustment had been possible. The single patients either abstained from sexual relationships, or had infrequent or unsatisfactory experiences. In many cases exhibitionistic activity was instituted in childhood, usually with concomitant voyeuristic tendencies. Also, in many cases, patients were arrested or voluntarily consulted a physician for treatment after some occurrence that was emotionally traumatic. Among the types of trauma cited which precipitated exhibitionistic acts in adult life were a broken engagement, death of the mother, and remarriage of the mother.

Rickles has summarized many of the common features, among which are included:

1. All patients are male, are extremely modest, and profess adherence to a strict moral code.

2. All patients are embarrassed by their behavior and they usually try to deny or disavow it.

3. Exposure always occurs before unknown women or children.

4. The patients report a building-up of extreme internal tension until they are unable to resist the urge to expose themselves publicly.

5. Sexual activity, such as masturbation, may be manifested during or after exposure, but such activity is not necessary for relief of tension.

6. The subject does not obtain relief from tension unless he has some definite indication that he has been observed in the act of exposure.

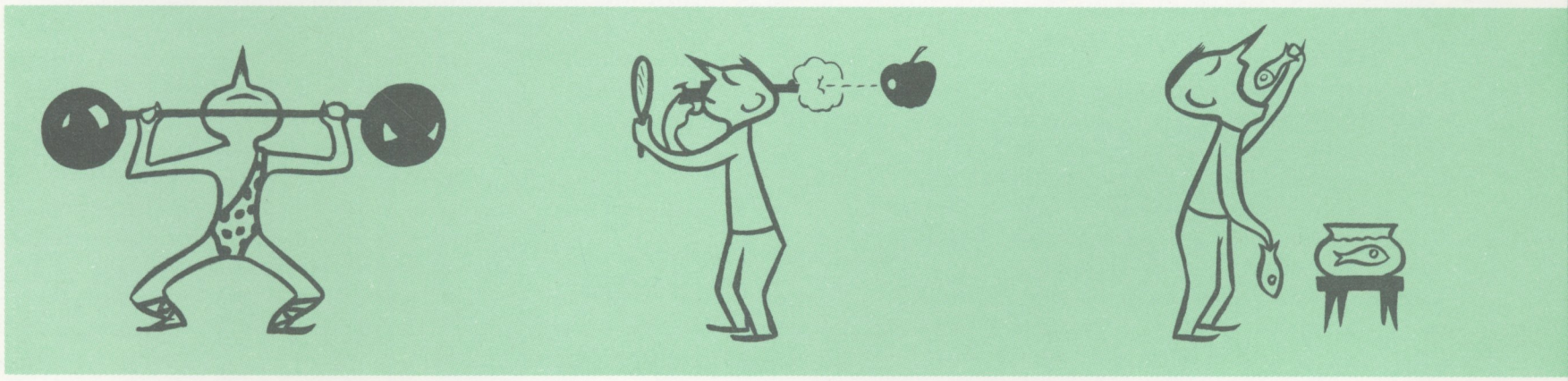
7. After exposure, the subject is depressed and he then resolves never to repeat the activity.

Statistics and medicolegal aspects of exhibitionism

Statistical studies admittedly afford only superficial impressions, but such materials do give factual data that are useful in delineating some of the common personality traits of the subjects. In the extensive *Report of the Mayor's Committee for the Study of Sex Offenses* in New York City for the period of 1930-39, exhibitionism was one of the specific types of sex crimes that were studied. A total of 3423 arrests were made for indecent exposure, and, of this number, there were 1561 arraignments with convictions in 1063, or 68 per cent. Most of the offenders were over 31 years of age and most of them were unmarried.

In Arieff and Rotman's study of 100 cases of exhibitionism, 84 per cent were over 17 years of age and under 40. The educational average of this group was high, including 12 men with college training. Sixty-two were single and 38 were married.

Henninger has reported 51 cases of exhibitionism. In this series, one subject was a mentally deficient woman; eight were classified as psychotic, ten mentally deficient; three were considered to be psychopathic



personalities; and four were chronic alcoholics. An additional four were designated as organic unstable personality types, two as psychoneurotic, 19 as essentially normal although emotionally unstable, and one as affected by marijuana intoxication.

In Ellis and Brancale's study of 200 sex offenders reported in 1956, 89, or 29 per cent, were exhibitionists. These investigators found alcoholism to be an important factor. Many of the subjects believed that they should be punished for their offenses, and most of them were willing to undergo psychiatric treatment.

All these studies demonstrate that exhibitionism represents 20 to 35 per cent of all sex offenses. More than 70 per cent of the offenders show evidence of some disturbance, with a range from the severe psychoses to the compulsive behavior disorders.

Treatment

Probably the greatest disagreement among physicians about exhibitionists concerns the efficacy of treatment. Most authorities do agree, however, that exhibitionism is a provocative medical, legal, and social problem that requires much more investigation. Early treatment of patients has proved to be fairly successful. Rickles, for example, reports complete rehabilitation in 15 of 17 cases of exhibitionism. Maslow and Mittelmann believe that treatment of the exhibitionist is difficult and involved, but can be successful if the person is dissatisfied with his behavior, has an intense desire to change, and if exhibitionism has not been practised for too many years. Ellis and Brancale emphasize that "minor" sex offenders such as exhibitionists are the most amenable of such offenders to psychotherapy and rehabilitation. They point out, however, that the current practice of dividing sex offenses into minor or major crimes on the basis of the presumed dangerousness is unrealistic and potentially disastrous. These authors make the further point that if some attempt is not made to afford treatment facilities for first offenders, subsequent offenses may be much more serious and menacing.

Conclusion

Exhibitionism has been variously classified as a perversion, an impulse neurosis, as a fundamental aberration of sexuality, and as a sociopathic character disorder. Aside from such "normal, displaced exhibitionism" as lavish adornments of clothing, exhibitionism may occur in two major forms of expression. First, it may be primarily an act of compulsive performance on the basis of profound distortion of sexuality, and, second, may be a secondary symptom without much nosologic significance in the psychoses and other disorders.

Studies of exhibitionism show that the subjects do not have the opportunity to develop a normal heterosexual pattern of behavior. As a result, the individual adopts the more deviant and socially unacceptable behavior. Exhibitionism is not rare, since it accounts for possibly 35 per cent of all sex offenses. In addition to the problem of helping the exhibitionist himself, there is another problem, that of protection of society. Obviously, in such offenses as pedophilia, there may be little choice besides forcible removal of the offenders from society, but in the case of the exhibitionist, incarceration in a penal institution does not solve any problem. Actually, imprisonment has proved to be useless as far as rehabilitation is concerned, and may even be actually harmful. Extensive studies of sex offenders attest to the fact that increasing the amount of punishment is not helpful, and that if adequate treatment is not given, there is always the chance that the offenders may repeat the offense, or may commit even more serious ones. Most investigators believe that the subjects can be helped by proper treatment, and that the most favorable prognosis can be expected in first offenders. Also, offenders under 30 years of age probably have a better prognosis than those over 30.

Although most exhibitionists are thought to be nonaggressive and not to constitute a physical threat to anyone, it has been pointed out that this attitude may be unrealistic. It is obvious that children may be subjected to some degree of emotional trauma in instances of exhibitionism and this is, admittedly, a social problem. Exhibitionism is also a medical and legal problem that necessitates further investigation before more scientific and humane disposition of the offenders can be made.

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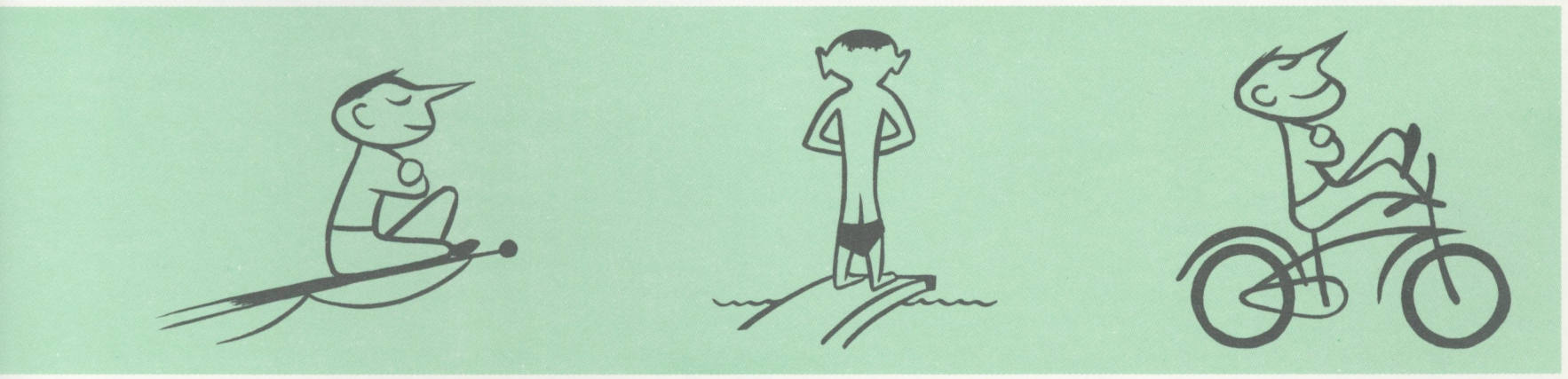


Psychopathology of the Modern Male

An interview with Dorothy Cato, B.A., M.D., Associate Professor Postgraduate School of Medicine, The University of Texas, Houston, Texas

In your opinion have the so-called "cultural shift" that altered man's place in society and the disruptions of military service contributed greatly to the disharmony of family life?

The primary approach to the cultural shift has been mainly through investigations in anthropology and sociology. There has been little in the psychiatric literature about the influence of cultural changes, although I think psychiatrists are becoming increasingly aware of some of these problems. Actually, I think they have, and we would do well, clinically, to consider both the anthropologic and socioeconomic alterations in our professional approach to individual psychopathology.

What would be your definition of the term "the absent father"?

The absent father can be graphically described as a man who is hermetically sealed. This vacuum-packed man is emotionally and spiritually absent from his family, with his only contribution a financial one. The physical presence is not the crucial factor. He may be gone often, or never; in either event he is seldom more than an animated suit of clothes. Occasionally, such a father can relate to one child, usually a daughter, but this exhausts his meager emotional capital. He is seen in all socioeconomic levels, in business or the professions. His endeavors are socially laudable. His behavior is ostensibly normal. He does not appear to be emotionally maladjusted. As a paternal figure, however, the substance of this man is indeed shadowy. He makes no effort to protect himself or his children from an unreasonable and demanding mother. I can cite one unusual example, in the case of a man who moved a large water heater from the kitchen to the cellar and then to the back porch rather than incur conflict with his wife. Such refusal to set limits provokes the woman to ever-increasing despotism as she tries unconsciously to force him to be a man.

How does he affect the children?

The father who is physically absent through death or divorce leaves a hiatus that it is possible, in some ways, to fill. The child may find a father substitute in male relatives or friends. The absent father creates a situation that is potentially more pernicious than exists when the parent is permanently away.

Why should this be true?

The fact that parents are not divorced gives them an illusion of an unbroken home and they are not aware of the consequences of an emotional divorce. Another factor is that the father does not afford the child either a real or fantasied masculine figure, but forces the son to pattern after an inadequate male image.

What kinds of clinical problems do sons of absent fathers present?

All I could tell you would be from my own observations and impressions. A large series of patients would be required to discover if the impressions are true. Personality disorders, paranoid personality, passive-aggressive personality, or homosexuality—latent or overt—seem frequent. Although the son may marry, he does not relate to his wife as a normal husband, nor to his children as a normal father. Such a man may force his wife into a little-girl role so that, by contrast, he can seem a man. He may bully his wife as his mother bullied his father, and thereby convince himself that he is a better man than his father.

Another result may be development of homosexuality. In this way the son can demonstrate another kind of power. He triumphs over his father by humiliating him. Obviously, the reasons for homosexuality are more complex than that, but it would be a mistake to overlook the actual importance of this factor.

What about resolution of the Oedipal conflict in such men?

Their masculine identification will only be partial. To be strong, the son must be like his mother. Or, if he identifies with the father, then he, too, will be ineffectually masculine with, as a result, development of either latent or overt homosexuality.

What effect has an indifferent father upon maturation of female children?

In my own case load this does not seem much of a factor in nonpsychotic women. In the few instances in which the effects of an indifferent father have been observed, the clinical impression is complex. Actually, the findings are difficult to define more precisely than as problems of personality trait disorder. For some reason, it appears that the absent father is able to establish a limited paternal relationship with a daughter, a relationship that is impossible for

him with a son. Perhaps it is because these fathers are comfortable only with miniature females, since their marital lives show an inability to relate to adult women. Daughters with such a paternal relationship seem to adjust better to marriage than daughters who have no paternal relationship at all. The father, you must remember, does not dislike or hate his offspring. He is just indifferent, a manifestation more intolerable than open rejection. At any rate, you can expect these women to have difficulties in relating to men because of their lack of a pattern of healthy familial relationships.

What happens if the daughter of such a father marries an emotionally healthy person who is able to relate normally to his family?

There are, of course, several possibilities. For instance, if the woman finds it impossible to reciprocate in a normal emotional way, she may become ill. If she is fortunate, she may marry a man who demands and helps her achieve and maintain an emotionally healthy relationship.

Would preparation for fatherhood, by a physician, ameliorate the siutation?

Sometimes the physician can afford a sufficiently adequate father-figure to his young patients to help them develop their stunted capacities. You know in the earlier studies of schizophrenogenesis only the mother was examined as an etiologic or pathogenetic factor. Later investigators of schizophrenic families showed the father to be alternately dominant or submissive to the wife.

Obviously, the best preparation for being a good father is to have had a good one. Many adults today are at a disadvantage because of such a lack.

Will you comment further about the absent father and the father with a schizophrenic family?

Athough the children do develop less serious disorders, they may be saved from schizophrenia if the mother is relatively healthy. If the mother is unstable, the children will probably become schizophrenic. It appears that a mother can have only a good or a bad relationship with her children. As a rule, she cannot be absent like the father. If the father is to be no help or emotional support, it is healthier, then, for him not to figure at all in the family relationships. This nonparticipation at least prevents the turmoil of clash between parents and constant changing of authority figures. This is not a good pattern, but it is consistent.

Do you think maternal dominance is as great as is popularly supposed?

It seems to me that both physicians and patients *expect* the mother to be the culprit. The domineering, omnipotent parent, the male head of the household and absolute ruler of the last century, was well recognized. In the modern situation, however, the non-functioning father has not been sufficiently considered as a factor in development of emotional illness. Sometimes, in taking the family history, it is readily apparent that if the mother in the family had not assumed leadership to some degree there would have been chaos indeed. The mother takes over, perforce, and often with unsatisfactory results. She merely fills the vacuum made by the negative pressure of the father.

How has this situation of the dominant mother come about in our culture?

An answer to that can only be speculative. There is no real validation, yet, of any of the situations described as cultural changes. For one factor, consider the human need for creativity. As man's inventions have increased, his individual importance to the world has been reduced. It is necessary to create, but each new implement, system, theory, or machine diminishes his own function, but, significantly, not that of women. Mechanization has lessened the distinction between "men's" and "women's" work. And, the important item is this: a woman can drive a tractor, fly an airplane, perform difficult calculations—and still bear children. This last-named creative ability is the source of the fundamental jealousy between the sexes. Male function in procreation is inadequate to answer the need to create, while the more realistic female maintains this "magical" potentiality. Men have, therefore, to build business empires, or statues, or structures to manifest their own products. Woman's involvement in the actual life process is much more basic than man's. Men, in general, have become aware of this fundamental truth, but have not yet discovered practical ways to recreate their own importance. Perhaps this is one reason why, in effect, they want to get to the moon.

At one time it was popularly supposed that women were much more easily influenced by emotion than men were. This idea has turned out to be a myth, as witness the performance of women jurors. They see through sham and confront the actuality, because they are, biologically, kept close to the factual.

What are other factors that influence paternal absenteeism?

Unfortunately, there are certain peculiar delimitations to masculine emotionality that are also cultural. The idea is accepted in our society that there are only a few reactions that men may properly feel and show. A man may demonstrate anger, for instance, at business or government. Reactions such as fear, pity, gentleness, anxiety, or affection are all for women. The man must emotionally be a robot. This convention may contribute to the man's removing himself emotionally, so to speak. In the family, feelings are evoked that must not be displayed.

Currently a man in emotional difficulty can properly get drunk, chase women, or seek outlet in work and thus be "male." Of course, such reactions are not more indicative of being a man than weeping and wailing are of being a woman. It is a curious truth that in the current culture only the extremely strong men can afford to show strong feeling. Heroes of history and literature commonly wept and stormed, but the typical modern male has no such right. It is, peculiarly, attributed to weakness; yet, strong and virile men, such as Churchill and Eisenhower, for example, can weep unashamedly. A characteristic of the sons of "absent" fathers is emotional sterility.

Would you consider the trend toward earlier marriages and larger families as conducive to better mental health?

It is too early to say whether this change is a healthful one, but it must represent a rather basic anxiety in both sexes. Perhaps it is related to the pervasive sense of peril of the atomic age, a manifestation of attempts to circumvent destruction.

Retribution and

In many kinds of emotional illness or maladjustment, guilt, whether conscious or unrecognized, coexists with an assumption of punishment. Sometimes the punishment is only expected, sometimes sought, and sometimes any disorder or event is interpreted as such. Patients may feel doomed or fated to undergo some tragedy or committed to a course of action that will culminate in disaster. Others may explain a chronic illness or develop a functional one as a retributive measure. Two related versions of this manifestation are described as the *talion principle* and the *nemesis concept*.

The Talion Principle

The idea of exacting an equal punishment—eye for eye—is an extremely old one and exists in most cultures. The mythologies and the early literatures of the world are full of expressions of that type of justice, and the development of legal systems was greatly affected by it. From a child's conditioned expectancy of punishment for a misdeed develops adult anticipation of "just deserts." In the neurotic patient this conviction of an implacable retributive force may take various forms. The individual may simply await punishment or invite it or he may find punishment, of the eye-for-eye variety, in any illness, injury, or misadventure. According to Fenichel, "The archaic conception of talion makes people feel that any suffering and any painful experience may undo guilt and entitle them to further compensating privileges." As to specificity of the punishment, castration fears in children are an example of this retaliatory concept. Again according to Fenichel, "the . . . organ that has sinned has to be punished."

According to some of Freud's early papers, repression of some form of sexuality was usually an etiologic agent. He wrote in 1910 of psychogenic disorders of the eye in relation to the talion principle and cited, for one literary example, the legend of Lady Godiva. Freud mentioned repression of scoptophilic wishes and resultant visual disturbance, or hysterical crippling of the hand in patients who had practiced and have subsequently ceased auto-erotic activities. Guilt, in instances like these, is assigned fairly precisely to some particular area of the body.

The Nemesis Concept

In the opinion of Chapman, the idea of talion may be just a part of what he describes as nemesis feeling —a whole pattern of life. Nemesis, of course, was the relentless goddess of retribution in the early Greek religion. Although the name has been used as a rough synonym for conscience or for a predetermined fate, her actual function was to see justice done by means of punishment. The chastisement, as in the talion principle, was approximately commensurate to the misdemeanor. Chapman describes as the core of some psychiatric disorders the patient's sense of destiny. In these patients there is a feeling of committal to a pattern, usually that of a family member or friend, and usually one who is dead. To such a patient the punishment consists in the compulsion to repeat the life pattern, often a tragic one, of another, sometimes one that he has wronged.

Obviously there will often be at least superficial resemblances in the life situation or the environment, and, equally often, patients will be found to have repeated particular examples (mainly parental) of reaction to a given set of circumstances. One effort at solution of an emotional conflict is by assumption of the life pattern of the other person, often one toward whom the patient's feelings

Neurosis

Meantime I seek no sympathies, nor need;
The thorns which I have reap'd are of the tree
I planted,—they have torn me—and I bleed:
I should have known what fruit would spring from a seed.

—Childe Harold's Pilgrimage

are ambivalent. Fears of insanity, of particular forms of death, or of chronic disease are sometimes related to this nemesis feeling, as representing a recapitulation of the parent's or the associate's sufferings. In such fashion the neurotic patient can allay his sense of guilt toward the "model."

Treatment

Patients who are aware of such feelings have difficulty in expressing them or, instead, a superstitious dread of doing so. Because of their reticence the physician may be unaware of this particular facet of the personality. It has been pointed out that the overt symptoms may be widely variable. Patients may be anxious, phobic, or obsessive, for example, but their basic fear is also their method of coping with the discomfort caused by their unresolved guilt.

The examples given of the talion principle in operation are also examples of unrealized guilt, probably only to be delineated after protracted therapy. The nemesis feeling, however, is one of which the patient may be much or partly aware.

In therapy the physician will, of course, see to the patient's real or imagined ills. Sometimes in the history he may get some clue to the disorder the patient dreads, expects, or fancies that he has. If he, for instance, finds examples of insanity in the near family members he may subsequently discover that it is with one such member that the patient has identified. The causes of death of the parents are also significant in this manner. Psychotherapy is important in the care of these individuals. In some patients only a few areas of existence are affected, so that they may be helped by discussion, explanation, environmental manipulation, or resolution of lesser problems. Some whose lives are more widely affected will require intensive psychiatric assistance. The immediately important matter is to discover this fear, and the reasons for it are usually apparent after its existence is established.

Chapman mentions that the reluctance to mention such feelings in the patient who is aware of them is not because of the implied guilt, which may be still unrecognized. It is, instead, a dread of "invoking Nemesis," so to speak, as if by verbalization of the idea the dreaded results would be put into more immediate effect. In his experience most patients realize a degree of relief when the therapist has been the one first to express verbally the frightening concept.

Conclusion

A nineteenth-century physician Abraham Coles, wrote of "The inappeas'ble Nemesis within." He was speaking of the guilty conscience. In the way the individual meets his own guilt feelings ideas of retribution may figure strongly. Patients require psychotherapeutic help, both for their psychosomatic ailments and for alleviation of such fears as may be explained away. In obsessional cases or in severe instances in which the concept of retribution affects all phases of the patient's living referral for psychiatric treatment is needed.

Suggested Reading

Chapman, A. H.: The Concept of Nemesis in Psychoneurosis, J. Nerv. & Ment. Dis. **129**:29 (July) 1959.

Coles, A., cited in Stevenson, B. (ed.): The Home Book of Quotations, 8th ed. New York, Dodd, Mead & Company, 1956, p. 301.

Fenichel, O.: The Psychoanalytic Theory of Neurosis, New York, W. W. Norton & Company, Inc., 1945, p. 44.

Freud, S.: Notes Upon a Case of Obsessional Neurosis, in Jones, E. (ed.): Collected Papers, Volume 3, New York, Basic Books, Inc., 1959, p. 296.

Freud, S.: Psychogenic Visual Disturbance According to Psycho-Analytical Conceptions, in Jones, E. (ed.): Collected Papers, Volume 2, New York, Basic Books, Inc., 1959, p. 105.

Quickies

CATAPLEXY: Cataplectic attacks are usually precipitated by laughter, but, according to Levin, aggressive impulses are the second most frequent stimulus. The aggression may be overt or symbolic but if it is related to guilt it can be an effective precipitant. Cataplexy represents conditioned inhibition and the attack may develop even in "playful" acts of aggression associated with sports or with practical jokes. It is still a form of response to guilt.

Levin, M.: Aggression, Guilt and Cataplexy, Am. J. Psychiat. **116**:113 (Aug.) 1959.

DELIRIUM TREMENS: In a study of 700 patients with delirium tremens, the author reported his findings in 45 patients with water and electrolyte disturbances and in 16 patients who died. Of the total group 82 per cent were males and 18 per cent females. Of the patients who died, infection was the direct cause in five. Six patients died from causes not directly related to delirium tremens. In five there was clinical evidence of swelling of the brain. Generally patients who die of delirium tremens have either cerebral edema or "overwhelming infection."

Krystal, H.: The Physiological Basis of the Treatment of Delirium Tremens, Am. J. Psychiat. **116**:137 (Aug.) 1959.

PSYCHIATRIC DIAGNOSES IN GERIATRIC PATIENTS: Of 524 patients who received psychiatric examinations, 301 were females, 223 males. All were hospitalized in an institution for aged indigent chronically ill patients. The average age was between 59 and 64 years, although the actual range was from 20 to 101 years. Diagnoses were divided into nine main categories and the findings considered as to differences in age, sex, and period of hospitalization. Chronic brain syndrome as manifest by senile brain disease was diagnosed in 72 females and 28 males, schizophrenic reactions in 52 females and 39 males. Central nervous system syphilis was reported in 30 males and in 13 females. Although all patients were chronically disabled it was surprising to find that ten females and eight males were evaluated as normal, with no psychiatric disease. The author points out that in aged patients physical and psychologic disorders may be confused in medical or administrative evaluation.

Mensh, I. N.: Psychiatric Diagnosis in the Institutionalized Aged, Geriatrics **14**:511 (Aug.) 1959.

SCHIZOPHRENIC CHILDREN: Schizophrenia in child patients is ordinarily expressed by physical manifestations. In a study of psychotic children, these clinical expressions were noted, some, if not all, of which were found to occur in every patient: (1) unusual movement of the body, such as robot-like motion; (2) repeated or stereotyped activity; (3) misuse of the body parts, such as manipulation of the whole body to represent a body part or of a body part to represent the whole; (4) postural or vocal expression of a nonhuman identity; (5) speech disturbances; (6) denial of the presence of other people in physical proximity, such as as an effort to utilize whoever is near as furniture; (7) disorientation as to time and space; (8) unsuitable or disproportionate affect; and (9) "hypertrophied interest" in a particular subject that happens to be associated with the disorder.

Kaufman, I., et al.: Parents of Schizophrenic Children Workshop, 1958, 3. Four Types of Defense in Mothers and Fathers of Schizophrenic Children, Am. J. Orthopsychiat. **29**:460 (July) 1959.

HOSTILITY AND RHEUMATOID ARTHRITIS: One personality factor that seems consistently to figure in patients with rheumatoid arthritis is that of hostility. Characteristically this hostility is suppressed and becomes onerous to the patient who cannot express ill will. While enmity as an etiologic factor is unproved the trait is demonstrable in sufficient numbers of patients to justify further study. In rheumatoid arthritis the age-adjusted rates are higher for married men than for bachelors, and are highest for divorced males. The findings are more conspicuous in male arthritics than in females. Seemingly, patients with rheumatoid arthritis are somewhat more likely to become divorced but they do tend to maintain unsatisfactory marriages for longer periods than do persons without rheumatoid arthritis. A sample study in Allegheny county of individuals seeking divorces seemed to substantiate the hypothesis, both as to the presence of strong hostility and in regard to the rigorous control as well.

Cobb, S., et al.: On the Relationship Between Divorce and Rheumatoid Arthritis, Arthritis and Rhematism **2**:414 (Oct.) 1959.

NERVOUS HABITS IN CHILDREN: The family physician has occasion to examine and to treat nervous children more often at present than was once the case. The child expresses his disturbance in one of four ways, usually, or in combinations of them. These are behavior disorder, psychoneurosis, psychosomatic illness, and psychosis. The emotionally unstable child seldom speaks directly of his problems. It is through the child's symptoms and habits that the physician gets information as to the kind and degree of disorder. Disturbances of conduct are common, among which "acting-out behavior" would be included. Some of the less serious examples of behavior disturbance are refusal of foods, nail biting, and restlessness. Somewhat more troublesome are learning disability, stuttering, and persistent aberrant sexual behavior. The author points out that any of these manifestations that becomes habitual does not necessarily connote illness. He also reminds that a symptom may endure, as a habit, for a long while after the original problem that occasioned it has disappeared or been overcome.

Lassen, T. J.: The Family Physician Meets Nervous Children, M. Times **87**:1339 (Oct.) 1959.

Book Reviews

• THE MEDICAL WORLD OF THE 18TH CENTURY. *By Lester S. King, M.D. Pp. 346. Price $5.75. Chicago, The University of Chicago Press, 1958.*

In ten essays, King has presented an informal series of views of 18th century science. This is not history in the detailed chronological sense, so much as it is a group of pictures that tell the story of a peculiar stage in the development of modern medicine. The book is documented, illustrated, indexed, and it includes a foreword by Ilza Veith, Ph.D.

Medical practices — both ethical and unethical—make for enjoyable reading in this volume. King has utilized contemporary accounts, prescriptions, and even verses to describe the era, with results both entertaining and instructive. Two chapters are given to the physician considered by King to be the most influential of his time, Hermann Boerhaave. The final chapter of the book contains actual day-by-day records in "a frankly empirical practice" that serve admirably to epitomize the medicine of the period.

• PSYCHOANALYSIS AND CULTURE. *Edited by G. B. Wilbur, M.D., and Warner Muensterberger, Ph.D. Pp. 462. Price $10. New York, International Universities Press, Inc., 1951.*

On the sixtieth birthday of Geza Roheim a collection of 27 essays was presented to and dedicated to him. Although the authors came from several disciplines, the orientation of the whole is largely—and naturally —anthropological. A variety of subjects is included in the volume, however, and the editors have divided the contributions into six groups for the readers' convenience. They are: Culture and Personality, Sociology, Epistemology, Mythology, Linguistics, and Art and Literature. PSYCHOANALYSIS AND CULTURE contains a bibliography of Roheim's works and a foreword by Sandor Lorand, M.D.

• DRUG ADDICTION: *Physiological, Psychological, and Sociological Aspects. By D. P. Ausubel, M.D., Ph.D. Pp. 126. Price $0.95. New York, Random House, 1958.*

According to his preface, Ausubel has surveyed the existing literature in order to give an integrated and documented summary of the problems and facts of addiction and the research that is in progress. While he has perhaps underestimated the amount and accessibility of literature on the subject and exaggerated its obscurity, the idea of a nontechnical informative presentation is indeed a good one. Bibliographically he makes no effort at coverage. The selective reference list is, however, briefly annotated in part. The author also provides a glossary of 30 terms.

• THE SPECIALTIES IN GENERAL PRACTICE. *2nd edition. Edited by Russell L. Cecil, M.D., and Howard F. Conn, M.D. Pp. 780. Price $16. Philadelphia, W. B. Saunders Company, 1957.*

This instructive volume is presented in an attractive new edition with some changes in format. The 1951 edition was slightly longer, but the different sections of this book have about the same relative proportions. Most of the illustrations are the same but there have been additions made to the bibliography. Also, T. George Bidder, M.D., has been added to Douglas D. Bond, M.D., and John M. Flumerfelt, M.D., for the section on psychiatry.

• OBSTETRICS AND GYNECOLOGY. *By J. Robert Willson, M.D., C. T. Beecham, M.D., I. Forman, M.D., and E. R. Carrington, M.D. Pp. 605. Price $10.75. St. Louis, The C. V. Mosby Company, 1958.*

This textbook developed from a summary form of the courses given at the Temple University School of Medicine in obstetrics and gynecology. The authors state their intent—which is to emphasize for the physician or medical student the structural and functional changes in the body that result from different obstetric or gynecologic conditions. The subject range includes preventive medicine, indications for consultation, and emotional and environmental factors that affect both the patient and her treatment. There is a short chapter on pediatric gynecology and a shorter one on the menopause and climacteric. The volume has a detailed index and 267 illustrations are used. Bibliographic references are given at the ends of most of the chapters of the text.

• CURRENT CONCEPTS OF POSITIVE MENTAL HEALTH. *By Marie Jahoda. Pp. 136. Price $2.75, and* ECONOMICS OF MENTAL ILLNESS. *By Rashi Fenn. Pp. 164. Price $3. Nos. 1 and 2 in the Monograph Series from the Joint Commission on Mental Illness and Health, Reports to the Staff Director, Jack R. Ewalt, M.D. New York, Basic Books, Inc., 1958.*

Findings from a nationwide mental health survey are being collected,

unified, and given as periodic reports with the ultimate intentions of a national planned program of mental hygiene from the recommendations. The first book gives the definition, plan, criteria, and research background. In the second of the series the statistics for computation of cost are explained. The economics involved are seriously to be considered, and the findings for this purpose have been tabulated in simple and orderly fashion. Both volumes are indexed and have bibliographies.

• Personality Patterns of Psychiatrists. *By Robert R. Holt, Ph.D., and Lester Luborsky, Ph.D. Pp. 386, 400. Price $7.50 for Volume I, $4 for Volume II. New York, Basic Books, Inc., 1958.*

This material is part of the Menninger Clinic Monograph Series and is subtitled, "A Study of Methods for Selecting Residents." The second book includes the supportive data and is intended to be used with the first rather than read afterward in sequence. In the foreword, Robert P. Knight, M.D., explains the circumstances of the study—how, from the largest center in the world for the training of psychiatrists, there would logically come an explanation of selection procedures for candidates.

In ten years of research and in examination of 466 applicants for training some principles of testing and rating have been developed, analyzed, and evaluated. The findings are now assembled by Holt and Luborsky, who are both themselves psychologists. Collaborators on these instructive volumes were William R. Morrow, Ph.D., David Rapaport, Ph.D., and Sibylle K. Escalona, Ph.D.

• The Psychoanalytic Study of the Child, *Volumes 12 and 13. Edited by Ruth S. Eissler, M.D., and others. Pp. 424, 582. Price $8.50 each. New York, International Universities Press, Inc., 1958.*

In 1958 two volumes appeared of this serial collection on the subjects of clinical and theoretical psychoanalysis in children, the latter volume of which was dedicated to the memory of Ernest Kris. As is customary in these books, the tables of contents of earlier numbers are included, and Volume 13 contains a bibliography of Kris's writings. In Volume 12 the most extensive of the contributions is by Edith Jacobson, M.D., on the subject of vacillations of mood, particularly of patients of the psychotic depressive type.

Volume 13 is a slightly larger collection and includes 22 papers from 34 contributors. Four of the papers presented along with the remarks of their discussants are from the Ernest Kris Memorial Meeting that was held in New York at the Academy of Medicine in September, 1957.

• Collected Papers. *By D. W. Winnicott, F.R.C.P. Pp. 350. Price $6.50. New York, Basic Books, Inc., 1958.*

Twenty-six scientific papers, given between 1931 and 1956, are arranged here in three groups, in some measure according to the author's changing clinical experience. Winnicott is both pediatrician and psychoanalyst, so that his works afford variety to more than one audience. He has also included case histories by way of illustration and instruction. The volume is extensively indexed and has a bibliography and illustrations.

Two contributions of especial interest are in papers that were read before the British Psycho-Analytical Society in 1935 and 1945. The former, "The Manic Defence," examines the concept of *inner reality*. The latter contribution develops the ideas of unintegration, dissociation, and regression, under the title "Primitive Emotional Development."

• A History of Neurology. *By Walther Riese, M.D. Pp. 223. Price $4. New York, M D Publications, 1959.*

Riese's history is the second of the MD Monographs on Medical History series, and, as such, is directed editorially by Felix Marti-Ibanez, M.D., who wrote the foreword to this volume. The formulation of the basic concepts of neurophysiology and the development of diagnostic and therapeutic procedures in this discipline were slow processes. The author relates them, historically, to development of other scientific theories, and, besides his interesting text, provides also a chronological table of the significant discoveries and achievements. A History of Neurology is stimulating reading matter with a variety of quotations that add to the interest. The book is illustrated, has subject and name indices, lists societies in the specialty and periodical materials on the subject, and affords, besides, a bibliography of 175 items.

• Progress in Psychotherapy, *Volume III. Techniques of Psychotherapy. Edited by Jules H. Masserman, M.D., and J. L. Moreno, M.D. Pp. 324. Price $8.50. New York, Grune & Stratton, Inc., 1958.*

The title of this individual volume seems unnecessarily to limit the subject matter contributed by 43 scientists from several different countries. In the presentation of techniques much ancillary material is included, of course, so that both history and rationale are largely represented before any particular methodology is described. Much the longest paper is that of Moreno on the rules and procedures of psychodrama. A group of six papers are offered in conclusion on the subject of foreign progress and developments in psychotherapy. The volume is indexed both by names and by subjects, and recent and useful references are given with most of the contributions.

BOOKS RECEIVED

Mystery on the Mountain: *Secret of the Sinai Revelation. By Theodore Reik. Pp. 210. Price $3.75. New York, Harper & Brothers, 1959.*

The World of Dreams. *By Henri Bergson. Pp. 58. Price $2.75. New York, Philosophical Library, Inc., 1958.*

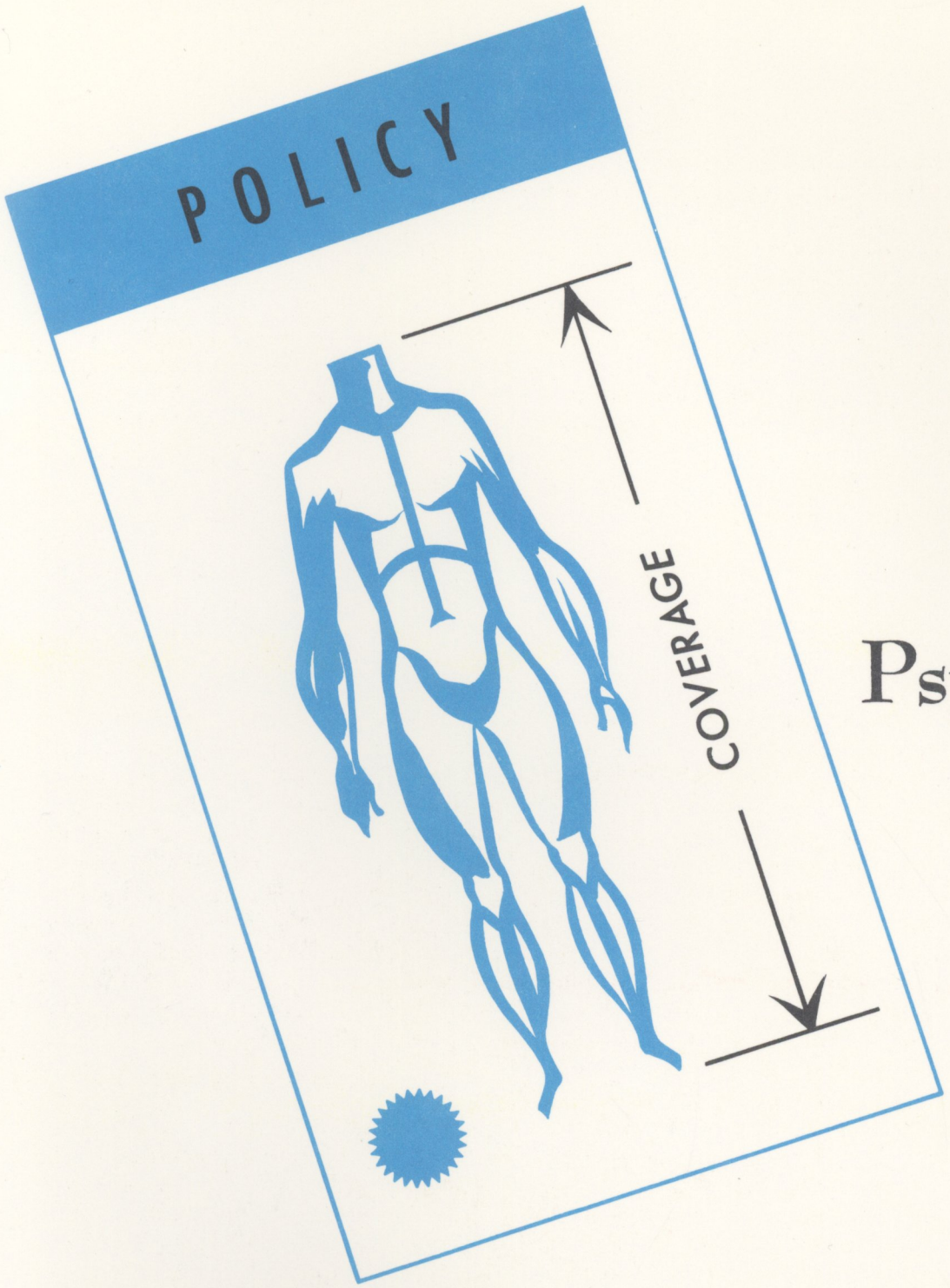
Mannerisms of Speech and Gestures in Everyday Life. *By S. S. Feldman. Pp. 301. Price $5. New York, International Universities Press, 1959.*

Mental Subnormality. *By Richard L. Masland, Seymour B. Sarason, and Thomas Gladwin. Pp. 442. Price $6.75. New York, Basic Books, Inc., 1959.*

Biological Psychiatry. *Edited by Jules H. Masserman, M.D. Pp. 338. Price $9.75. New York, Grune & Stratton, Inc., 1959.*

Principles of Self-Damage. *By Edmund Bergler, M.D. Pp. 469. Price $6. New York, Philosophical Library, Inc., 1959.*

Language and Psychology. *By Samuel Reiss. Pp. 299. Price $3.75. New York, Philosophical Library, Inc., 1959.*



Insurance for Psychiatric Care

Mike Gorman, Executive Director for the National Committee Against Mental Illness, spoke last year on the subject of the costs of psychiatric treatment and care. In a reminder of the number of persons in this country who are unable to pay for therapy and of the prevalence of the disorder that was under discussion, he pointed out that the originator of modern psychiatric procedures had understood the problem long before there was any public acknowledgement of it.

In 1919 Sigmund Freud spoke on the duty of the community toward the mentally ill and stated that, in his opinion, the indigent had as much claim upon public resource for psychiatric help as for medical and surgical treatment. With modern programs of health insurance the individual can provide himself with coverage in instances of surgical disorders, for example, but with one of the most common ailments in the whole United States his insurance may not be effective. It is, indeed, a grave problem and one which requires immediate solution.

Since 1941 the Dallas Blue Cross plan has been in operation with insurance coverage for psychiatric illness. A cost study of the actuarial findings was instructive as to the total claims that were made. In more than 12,000 consecutively reported patients heart diseases occasioned from five to six per cent of all claims. Mental and emotional disease, however, amounted to about half that figure, that is, 2.7 per cent of all claims. Thus, the cost of such indiscriminate coverage has been previously overestimated, and insurance programs to include mental illness need not be predicated upon riders to policies or upon exaggerated figures for hospitalization costs.

No one at present can seriously contend that economic status has no effect upon patient care. As the nation becomes increasingly conscious of the far-reaching effects of emotional disturbance, mental disorder, and alcohol and drug addictions, it will have also to take increased notice of the means available to people in lower income groups of meeting these problems. If understanding of a problem is truly the first step toward solution of it, then, in this country, provision for bearing the expenses of psychiatric disorders should surely be under practical consideration at this time.

Reference

Gorman, M.: All Health Insurance Plans Must Cover Mental Illness, Statement made at Public Hearing of the New York State Joint Legislative Committee on Health Insurance Plans, Thursday, Nov. 13, 1958, State Office Building, Buffalo, New York.

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"There is nothing either good or bad,
but thinking makes it so."

—HAMLET